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| | 055612 | A. BUILDING _____ B. WING _____ | C 05/22/2023 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during the investigation of two Facility Reported Incidents (FRIs).<br><br>Facility Reported Incident Numbers: CA00834964 and CA00828829<br><br>Representing the Department:<br><br>Health Facilities Evaluator Nurse: 43739<br><br>The inspection was limited to the specific Facility Reported Incidents investigated and does not represent the findings of a full inspection of the facility.<br><br>No deficiencies were issued for Facility Reported Incident CA00834964.<br><br>One deficiency was identified for Facility Reported Incident CA00828829 at F689. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to follow the physician order and | F 689 | | |

RECEIVED
09 June, 2023 11:29 am
CA DEPT OF PUBLIC HEALTH
CHCQ Field Operations North Division- Chico

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristen Schell | TITLE: Administrator | (X6) DATE: 5/31/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 689 | Continued From page 1<br>implement interventions to prevent unsafe wandering and elopement (when a resident leaves the premises or a safe area without authorization or necessary supervision to do so) for one of three sampled residents (Resident 1). As a result, Resident 1 eloped to the outside of the facility and fell.<br><br>Findings:<br><br>A review of the facility ' s policy titled, "Elopements and Wandering Residents", revised date not provided, indicated: "1. This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. 2. "Wandering" is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless. 3. "Elopement" occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. 4. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 5. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. The interdisciplinary team (IDT) will | F 689 | | |

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| F 689 | Continued From page 2 | F 689 | | |

evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident ' s risk, modify the resident ' s behavior, or to minimize risks associated with hazards will be added to the resident ' s care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 6. Procedure Post-Elopement - A nurse will perform a physical assessment, document, and report findings to physician. Any new physician orders will be implemented and communicated to the family/authorized representative. Documentation in the medical record will include: findings from nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable.

A Review of Resident 1 ' s admission record, indicated that Resident 1 was admitted to the facility on 7/12/2018, and was later diagnosed with Alzheimer ' s disease (It is a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), muscle weakness (generalized), and bilateral hearing loss on 7/7/2022.

A review of Resident 1 ' s Minimum Data Set (MDS - an assessment and care screening tool), dated 3/4/2023, indicated a Brief Interview for

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|---|---|---|---|---|
| F 689 | Continued From page 3 | F 689 | | |

Mental Status (BIMS-assessment of cognitive status) score of 5 out of 15 points which indicated Resident 1 had severe cognitive impairment. Her behavior assessment indicated that she wandered every 1 to 3 days, and the wandering significantly placed the resident at risk of getting to a potentially dangerous place and intruded on the privacy of activities of others.

A review of Resident 1 ' s Nurses Note, dated 10/21/2022 at 3:30 am, indicated that Resident 1 was found sitting in wheelchair outside of building near room 7. Resident 1 was last seen sitting in wheelchair in her room at around 3:10 am.

A review of Resident 1 ' s Nurses Note, dated 2/16/2023 at 6:19 pm, indicated that Resident 1 was found outside in the front parking lot. The note indicated, "[Resident 1] stated that she was looking for her parents. [Resident 1] continuing to attempt to leave the facility, going through doors and her siding glass door. [Resident 1] to be place on one-on-one [1:1 - assigning a dedicated staff member to tend only to one particular resident around the clock to avoid the incidence of harm to the resident]. Medical Doctor 1 [MD] notified ..."

A review of Resident 1 ' s clinical record titled, "e-INTERACT (Interventions to Reduce Acute Care Transfers- is a quality improvement program that focuses on the management of acute change in resident condition) SBAR Summary for Providers" (SBAR - an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication), dated 2/16/2023 at 6:21 pm,

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| F 689 | Continued From page 4 | F 689 | | |

indicated that Registered Nurse (RN) 1 reported Resident 1 ' s elopement incident that happened earlier that night to MD 1 and MD 1, "responded with the following feedback: A. Recommendations: 1:1 to keep resident safe" B. New Intervention orders: 1:1."

A review of Resident 1 ' s Nurses Note, dated 2/17/2023 at 4:55 pm, indicated that Resident continued to go outside. The note wrote "She was found outside in front at garbage cans ... [Resident 1] became agitated and stated she was wanted to see her sister ...[Resident 1] was placed on 15 minute checks [a safety check is performed by the staff every 15 minutes] for safety ..."

A review of Resident 1 ' s Nurses Note, dated 2/25/2023 at 7:15 pm, indicated that Resident 1 was found outside of the facility on the path to the parking lot. The note indicated, "[Resident 1 ' s] wheelchair was tipped over and [Resident 1] was sitting up on the pavement with her feet in front of her ..." Resident 1 complained of pain to her right knee and left ankle. She was sent out to the local hospital for further evaluation.

During a concurrent interview and record review on 5/3/2023 at 10:04 am, the Director of Nursing (DON) reviewed Resident 1 ' s physician's orders and care plans. DON admitted that she could not locate the order and the care plan for "1:1" care. DON stated that the normal process was that the nurse should put in the order, create a care plan, then notify the Director of Staff Development (DSD) and the DSD would have an extra staff scheduled for 1:1 care. DON said, "it ' s bothersome that the nurse would miss the order

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| F 689 | Continued From page 5<br>and did not put it in ..."<br><br>During a concurrent interview and record review on 5/3/2023 at 10:30 am, the Dietary Manager (DM) confirmed that Resident 1 ' s care plan did not include one-on-one care. DON and DM also confirmed that there was no IDT meeting for the elopement incidents occurred on 2/16/2023 and 2/17/2023 as it should have per the facility policy. DM stated "How can no one see her going out...It ' s a small building, someone should have seen her ..."<br><br>During a concurrent interview and record review on 5/3/2023 at 11:27 am, DON reviewed the facility record titled, "Daily Certified Nursing Assistant (CNA) Group Assignments", dated 2/25/2023. DON stated that on the afternoon (PM) shift, CNA 1 was assigned to Resident 1 only, and did not have any group assignment which indicated that CNA 1 was on one-on-one care for Resident 1. DON also stated that CNA 1 no longer worked at the facility.<br><br>During a concurrent interview and record review on 5/3/2023 at 3:50 pm, RN 1 reviewed Resident 1 ' s clinical record and admitted that he made a mistake and said that he did contact MD 1 on 2/16/2023, and received an order of 1:1 care for Resident 1. RN 1 stated, "ideally, I should make a nursing note, input the physician order, resident on 1:1 due to elopement, and ask a CNA to do a 1:1 ...Ideally, I had to create a care plan for this, but I didn ' t ..." RN 1 also stated that for one-on-one care, a CNA would always sit with the resident. RN 1 said, "CNA was expected to be with the patient. It ' s directly assigned to the CNA ..." | F 689 | | |

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| F 689 | Continued From page 6<br><br>During an interview on 5/3/2023 at 4:13 pm, CNA 2 acknowledged that she was the staff who noticed Resident 1 was missing and found her outside the facility on 2/25/2023. CNA 2 stated that she did not know what she had to do for one-on-one care and said, "for one-on-one care, to sit with them, I guess ...I hadn ' t been trained for that ..." CNA 2 also stated that she wasn ' t aware that CNA 1 was assigned to Resident 1 for one-on-one care. She stated that she did not see CNA 1 with Resident 1 before and after the incident happened. CNA 2 stated, "I felt sad that Resident 1 was out there by herself. She looked scared like she did not know what to do. I did not know CNA 1 was supposed to be with her ..." | F 689 | | |

This Plan of Correction constitutes the facility's written allegation of compliance for the deficiency cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law.

This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or set forth in the statement of deficiencies.

F689 Free of Accident Hazards/Supervision/Devices

It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents.

**What corrective action(s) will be taken for resident(s) identified to have been affected by the deficient practice:**

Following Resident 1s February incident, all staff were in-serviced on this facility's elopement policy and procedure by the DSD. On 5/3/2023, Resident 1 was transferred to an appropriate care facility's memory care unit.

**Identification of other residents having potential to be affected by the deficient practice and corrective action.**

At the time of this writing, all residents with behaviors and tendency to wander or elope have the potential to be affected by the deficient practice. All staff have been in-serviced on March 24, 2023 by the DSD regarding documentation of events in risk management. IDT staff will be in-serviced to the facility's policy for wandering or elopement of residents, and procedure for implementing safe interventions as well as communication to all staff regarding interventions by the DSD and Admin. All staff will be in-serviced to the duties of a sitter position by the DSD.

**Measures that will be put into place to ensure deficiency does not recur.**

DON or designee will determine residents' behaviors of wandering and risk, such as falling. DON or designee will update communication of resident that are at risk of elopement in the elopement binder situated at the nursing station no less than quarterly. Staff will communicate changes of condition and document to changes and resident behaviors in PCC for IDT follow up post incident. Administrator will in-service IDT on identifying diagnosis and behavior in new residents, MDS triggers, interventions to ensure resident safety, follow up that resident's safety is maintained, and post-incident procedure. DSD or designee will be in-serviced all staff on the sitter guidelines and safe approaches for residents with dementia.

**Measures that will be implemented to monitor the continued effectiveness of the corrective action to ensure ongoing compliance.**

Medical records will conduct daily change of condition audits pertaining to any resident. Audits will be reviewed by DON or designee.

The facility Quality Assurance Performance Improvement (QAPI) Program will address no less than monthly any incidents and assess effectiveness of interventions placed for any resident deemed at risk and competencies of staff in regard to any incidents that have occurred. This will be assessed no less than monthly at the Quality Assurance meeting. Any trends identified will be forwarded to the QAPI program for a plan of correction and will be monitored until the threshold is met.

**Completion date.**

June 5, 2023.